FCA Information Request – General insurance value measures pilot

Scope

General Insurance products
List of pilot products (excluding reinsurance contracts):

- Home (buildings and contents) - Contracts of insurance against loss of or damage to both the structure of domestic properties and contents of domestic properties and including cover against risks to the persons insured incurring liabilities to third parties arising out of injuries sustained within the boundary of a domestic property.

- Home emergency sold as a stand-alone product or as an add-on to home insurance - Contracts of insurance relating to household assistance which fall within class 18. For the avoidance of doubt, contracts of insurance which include an element of service fall within this category provided they relate to household assistance.

- Personal accident sold as an add-on to motor insurance and home insurance – contracts of insurance sold as an add-on which fall within classes 1 or 2 of the 2001 Regulated Activities Order and which are not medical expenses cover, healthcare cash plans, travel and creditor

- Key cover sold as an add-on to motor insurance – Contracts of insurance sold as an add-on to motor insurance and relating to cover for lost, stolen and/or broken keys.

Sales
Sales to individual consumers in the UK are within scope. Group policies are out of scope.

Reporting responsibility
Insurers will be responsible for reporting on the products that they underwrite, including where they have set up delegated underwriting authority arrangements.

Lloyd's managing agents will be responsible for reporting on the products where they manage the underwriting capacity of Lloyd's syndicates.

Reporting period
The first reporting period is the year ended 31 August 2016. We anticipate there will be a second reporting period for the year ended 31 August 2017.

Reporting thresholds
Insurers will be required to report data for each of the products in the pilot provided they meet for each product both thresholds set out below:

	Must meet both thresholds	
	Total retail premiums (written)	**Average policies in force during the relevant period**
Home (Buildings and contents)	> £1,000,000	> 3,000
Home emergency	> £400,000	> 3,000

Personal accident (add-on)	> £400,000	> 3,000
Key cover (add-on)	> £250,000	> 3,000

Scenario: If total retail premiums written for personal accident in the relevant period exceed £400,000 and there are over 3,000 average policies in force then the firm should complete the relevant rows of the attached spreadsheet for that product.

In addition to completing the attached spreadsheet proforma please provide the following information (which we will be collecting but not publishing):

1. Copies of product reviews for the pilot products from 1 January 2015 to 31 August 2016.

2. Most detailed management accounts information (including claims management) covering the pilot products for 2014, 2015 and year to date 2016.

3. Where applicable please provide details of changes in the product design (since 1 January 2015) for the pilot products including price changes and changes to terms and conditions. Please include copies of minutes from pricing and other internal committees as well as other relevant papers considered by those committees in making changes to the pilot products (including changes in the sales approach or distribution of these products).

Notes on completing the proforma

Note	Proforma	Guidance (for the purposes of the pilot)
1	Add-on and stand-alone sales	For add-ons – only report as an add-on where it is a separate policy. For the purposes of the pilot an add-on is a general insurance policy bought alongside or in connection with a primary product. Where a product/cover is an optional extra within a policy, a cover option or part of the standard cover of home, the data for that product/cover should be included in the reporting for home. Stand-alone = A general insurance policy not sold alongside or in connection with another policy.
2	Distributors and brands (largest 5 for each reporting row)	For example list the largest (by level of retail premiums for that reporting row) five distributors/ brands for that reporting row.
3	Number of policy sales to UK consumers	This would not include group policies, but is instead based on the number of individual policies sold to UK consumers. This includes renewals as well as new sales. This will be the number of sales in the year ending 31 August 2016 (regardless of the period covered by the sold policies).
4	Total retail premiums (written)	This is the total gross retail premiums, based on the premiums charged to the end consumer (net of IPT), for the policy sales to UK consumers (see note 3). The reported data should exclude adjustments to premiums resulting from mid-term adjustments or cancellations as well as excluding other income such as cancellation fees, change of address fees and other fees and charges related to the policies.
5	Average premium	Total retail premiums (written) (see note 4) divided by the number of policy sales to UK consumers (see note 3)
6	Number of claims registered	Number of claims registered in the year ended 31 August 2016. Claims registered means a report or communication from a retail customer to raise a claim on their insurance policy, where the insurer has registered the claim on their system. *Scenarios* Where an event covers multiple claim components this should be treated as a single claim. Where a customer contacts the firm to report an event as required under their insurance policy but does not wish to make a claim, this should not be treated as a registered claim.

Note	Proforma	Guidance (for the purposes of the pilot)
		Where a customer initially calls to make a claim and is advised at that time that the loss is not covered or the claim is below the policy excess and decides not to pursue a potential claim further then this should not be treated as a registered claim. Where a claim is registered but not subsequently pursued (ie the customer does not contact the firm again) then the claim should be included within claims registered.
7	Average number of policies in force	Average policies in force (excluding group policies) during the year ended 31 August 2016 – based on the number of policies in force at the end of each month during the year, and dividing the total by 12 to arrive at an average for the year.
8	Claims frequency Data for claims frequency will be published in bands.	Number of claims registered (see note 6) divided by the average number of policies in force (see note 7).
9	Number of claims where all or part of the claim has been accepted and a pay-out has been made and the claim is closed at the year end (e.g. 31 August 2016)	This should include all claims where a firm has paid-out on a claim during the year and there are no elements of the claim which are outstanding at the year end (i.e. the claim is closed or settled). *Scenarios* If a firm pays out on one element of the claim, but is still investigating another element of the claim at the year end (i.e. the claim is still open) then this claim acceptance would be captured in the year that the final pay-out has been made and the claim closed. If a firm pays out on one or more elements of a claim, but rejects other elements of the claim (and the claim is now closed) then these claims should be included in this data field. If a firm pays out on one or more elements of a claim and there are no outstanding elements of the claim at the year end, these claims should be included. If in the subsequent period, the claim is reopened then this subsequent element of the claim should not be included in this data field.
10	Number of claims that have been rejected in the year	Claims rejected will include claims registered which are subsequently declined/rejected for the following reasons: - Claims declined because of fraud except for cases of proven fraud (which should be excluded from declined claims). For the purposes of the pilot, proven fraud will be cases meeting the Insurance Fraud Register definition of insurance fraud (http://www.theifr.org.uk/en/faqs/#1175). - Claims rejected because of breach of condition of the policy (for example where a claimant failed to notify the insurer within an appropriate time period after an event that was likely to result in a claim)

Note	Proforma	Guidance (for the purposes of the pilot)
		- Claims rejected because there is no cover (for example, where there may be exclusions under the terms and conditions) <u>*Scenarios*</u> Where a firm rejects one element of the claim but other element(s) of the claim are still being investigated and are outstanding then this partial rejection should not be included in this data field for this year. However, if in the following year the remaining elements of the claim are rejected then the claim should then be included in this data field for that year. Where a firm accepts one element of the claim but rejects another element of the claim this claim should not be treated as a rejected claim. Where a claim has been rejected because the policy has been voided – this should be excluded from the rejected claims. Where a customer has contacted the wrong insurer to make a claim – this should not be included in the data. Where a customer contacts the firm to enquire whether they are covered for a claim and are informed that they are not covered and the claim is not registered – this should be excluded from the rejected claims. Where a claim is registered and then the claimant decides not to pursue the claim or decides to withdraw the claim this should not be included within rejected claims. Where a claim is registered and accepted by the insurer, but no pay-out is made because the claim is less than the policy excess then this claim should not be included within rejected claims. Where an insurer is part of a panel and the panel provider may not record which of the insurers on the panel that a claim was rejected by or on behalf of – allocating a proportion of rejected claims in line with the insurer's share of the business could be reasonable basis for estimating the number of rejected claims.
11	Claims acceptance rate Data for claims acceptance rate will be published in bands.	= (Number of claims registered (see note 6) less the number of claims that have been rejected in the year (see note 10)) divided by The number claims that have been registered (note 6).
12	Total claims pay-out cost (for claims where all or part of the claim has been accepted and a pay-out has been made	For the claims where all or part of the claim has been accepted and a pay-out has been made and the claim is closed at the year end (note 9) the claims pay-out cost includes: - Total monetary value (£) of direct claim pay-outs to policy beneficiaries;

Note	Proforma	Guidance (for the purposes of the pilot)
	and the claim is closed at the year end).	- Other costs incurred by the firm which directly benefit the customer (e.g. the cost to repair a damaged wall for a home insurance claim or the cost of a home engineer for a home emergency claim); - Specific claims costs incurred handling of individual claims. This could include claims investigation costs; - Costs of providing a regular service element such as a helpline or a boiler service for home emergency. These costs should be allocated across the customers that use these services rather than only to customers where a claim is made. In your data submission, where possible, please separate the costs of providing a regular service element from the other costs included in the total claims pay-out cost. These costs could include both internal and external outsourced costs, where relevant. For example loss assessment activities performed in-house could be included, including both the direct cost and an appropriate apportionment of overheads. <u>*Excluded costs*</u> - Expenses including costs associated with the general handling of claims - Other non-claims costs <u>*Scenarios*</u> Where part of the claim was paid-out in the previous year but part of the claim was still outstanding at the year end the final pay-out in respect of the claim took place in the current period, then the claim pay-out that took place in the previous year should be included in the calculation for the current period. Where a claim has been closed/settled in the previous year but the claim has been reopened in the current year, any additional claim pay-out should be included in this field. Where firms subsequently receive recoveries from other firms these recoveries should be netted off against the relevant claim pay-outs. Where a claim is settled, but the settlement include a regular payment element then the settlement value as it is reported on the firm's system should be included in the cost.
13	Average claims pay-out Data for average claims pay-out will be published in bands.	Claims pay-out cost (see note 12) divided by the number of claims where all or part of the claim has been accepted and a pay-out has been made and the claim is closed at the year end (see note 9).